

Case Number:	CM15-0197485		
Date Assigned:	10/12/2015	Date of Injury:	12/17/2001
Decision Date:	12/01/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	10/07/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 66 year old male who sustained a work-related injury on 12-17-01. Medical record documentation on 8-10-15 revealed the injured worker was being treated status post L2-S1 anterior and posterior fusion in 2004, and post-operative L5 neuropathic pain. He reported continued left-sided back and upper buttock pain with constant radiation of pain down the left lateral thigh through the lateral calf to the great toe. He reported left paraspinal pain at the L2-3 region. He rated his left side back and buttock pain a 4-6 on a 10-point scale with medications and an 8-9 on a 10-point scale without medications. Previous treatment included left sacroiliac joint block with arthrogram with at least 75% improvement in the left buttock, posterior thigh and left calf symptoms. His medication regimen included Flexeril 10 mg, Lidoderm 5% patch, Lyrica 100 mg, morphine Sulfate ER 15 mg, Alprazolam 0.5mg, Atenolol 25 mg, Losartan Potassium 25 mg, Pantoprazole Sodium DR 40 mg, Provigil 200 mg, Terazosin 10 mg, Zolpidem Tartrate 10 mg, Ambien 10 mg, Cymbalta 60 mg and Nucynta 100 mg. Objective findings included a normal gait with no evidence of limp or weakness with toe and heel walking. He had tenderness to palpation over the left sacroiliac joint. He had decreased sensation over the left L4, bilateral L5 and right S1 dermatome distribution. His motor power was within normal limits. He had a positive straight leg raise at 70 degrees on the left and negative straight leg raise on the right. He had positive Fortin's on the left sacroiliac joint, positive pelvic distraction on the left, positive posterior thigh trust on the left and positive pelvic compression on the left. The evaluating physician noted the need for an EMG-NCV of the bilateral lower extremities due to hyperesthesias of the left L5 dermatome to determine whether there is an active radiculopathy

Vital signs chronic reinnervation changes. A request for EMG-NCV of the bilateral lower extremities was received on 9-4-20-15. On 9-11-15, the Utilization Review physician modified EMG-NCV of the bilateral lower extremities to EMG of the bilateral lower extremities only.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

EMG/NCV of bilateral lower extremities: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 7/17/2015), Electrodiagnostic studies (EDS), Electromyography.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Per MTUS ACOEM p182, with regard to the detection of neurologic abnormalities, EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent is not recommended. The documentation submitted for review does contain evidence of neurologic dysfunction. The medical records submitted for review noted left sided hyperesthesias in the left L5 dermatome. Decreased sensation was noted over the left L4, bilateral L5, and right S1 dermatome distributions. I respectfully disagree with the UR physician. This is an atypical case, post fusion. The MRI done in 6/2015 may not demonstrate the existence of scar tissue as the surgery was in 2004. The request is medically necessary.